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MEMORANDUM

TO:
Legislative Oversight Committee Members
Local CFAC Chairs
NC Council of Community Programs
County Managers
State Facility Directors
LME Board Chairs
Advocacy Organizations
MH/DD/SAS Stakeholder Organizations
Commission for MH/DD/SAS
State CFAC
NC Assoc. of County Commissioners
County Board Chairs
LME Directors
DHHS Division Directors
Provider Organizations
NC Assoc. of County DSS Directors

FROM: Dr. Craigan L. Gray
Leza Wainwright

SUBJECT: Implementation Update #62
CSS Transition and NC-TOPPS
Revised Discharge/Transition Plans for CSS/Level III & IV
Medicaid-Funded Enhanced Services Ages 18-20
Provider Responsibility for Retention of Records
Endorsement Update
Medicaid Enrollment Effective Date
CAP-MR/DD Update
Medicaid Reimbursement Rate Update
Notice of Medicaid Identification Card Changes

Community Support Service Transition and NC-TOPPS

The NC-TOPPS policy for Community Support transitional planning will remain consistent with the current SFY 09-10 NC-TOPPS Implementation Guidelines regarding consumer participation requirements in NC-TOPPS for consumers receiving certain designated services. The listing of mental heath and substance abuse services that require NC-TOPPS is provided on page 14 of the SFY 09-10 NC-TOPPS Implementation Guidelines, effective July 1, 2009; this document is published on the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) web page:
http://www.ncdhhs.gov/mhddsas/announce/commbulletins/commbulletin104/nc-toppsguidelinesjuly09.pdf

Participation in NC-TOPPS for the consumer will be based exclusively on the type(s) of service(s) that the consumer is going to, not on the type(s) of service(s) that the consumer is coming from. Please note that Psychosocial Rehabilitation (PSR) is not currently among those services requiring NC-TOPPS.

The local management entities (LME) should work with their provider agencies to facilitate the transfer of active cases within NC-TOPPS to the new provider agencies serving these consumers.

Revision of the Adult and Child Discharge/Transition Plan for Community Support and Residential Level III and IV Initial Authorization and Reauthorization Process

The Adult and Child Discharge/Transition Plan for Community Support and child Residential Level III and IV from Implementation Update #60 has been revised based on feedback from the Community Support Transitions Sub-Committee. The purpose of the revisions is to provide clarification regarding the use of the forms (e.g. forms utilized for authorization and reauthorization) and to ensure consumer and family involvement in the discharge/transition planning process.

Revisions to the Discharge/Transition Plan forms for adult and child Community Support and child Residential Level III and IV include the following:

- The consumer name and provider service record number are required in the header. The date has been deleted.
- One additional item was added to the header of each form (Child and Adult): For children, the date the Child and Family Team met to develop this discharge/transition plan and for adults, the date of the PCP planning participants met to develop this discharge/transition plan.
- Language was added noting that the plan is for initial authorization and reauthorization; therefore, the required PCP may be the introductory, complete or updated version.
- The requirement for submission of reauthorizations for Child Residential Level III and IV to include a new comprehensive clinical assessment by a psychiatrist (independent of the residential provider and its provider organization) that includes clinical justification for continued stay at that level of care as referenced in Implementation Update #60 was added.
- All discharge dates referenced on the form are to be "expected" discharge dates.
- A blank for indicating the date of the engagement of natural and community supports was added. This is to be the date the discharging provider has a discussion with the natural supports resource regarding the supports to be made available and is not necessarily the initial date support is provided to the consumer.
- The signatures of the recipient and/or legally responsible person were added and are required as evidence of their participation in the discharge/transition process.

All sections of the discharge/transition plan must be completed. Please see attachments entitled Adult and Child Discharge/Transition Plan; these revised plans will be required as of **November 2, 2009.**

Medicaid-Funded Services for Recipients Ages 18-20

This is a reminder that Medicaid recipients ages 18-20 are able to receive mental health and substance abuse services that are otherwise limited to adults if they meet medical necessity criteria for the service. With the exception of requests for Adult Facility Based Crisis for this age group, requests for other adults-only services do not require an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) exception.

Provider Responsibility for Retention of Records

As noted in Implementation Update #60, various decisions were made during the last session of the General Assembly in Session Law 2009-251(Senate Bill 202) which have direct implications for the community of mental health, developmental disabilities, and substance abuse (MH/DD/SA) providers. All providers, including directly enrolled Medicaid providers, are responsible for maintaining custody of the records and documentation to support service provision and reimbursement for the required retention period for publicly funded MH/DD/SA services.

In the event that a provider agency ends services, or dissolves for any reason, the provider is required to make arrangements to continue safeguarding both the clinical and reimbursement records in accordance with the record retention guidelines. Furthermore, in the case of mergers, there should be a clear delineation of how the records from all the entities involved will be retained. Termination of enrollment, dissolution of a business, or merger with another agency does not relieve the provider of responsibility for the records generated during the time the provider was in business.

The two schedules that address the retention and disposition requirements for publicly-funded MH/DD/SA services are the *DHHS Records Retention and Disposition Schedule for Grants* which is based on the funding source, and the *Records Retention and Disposition Schedule for State and Area Facilities*, Division Publication, APSM 10-3 which is organized by record type. Providers are subject to the applicable standards outlined in both schedules.

- The clinical records of children must be maintained for twelve (12) years after the age of majority (i.e., until the person reaches age 30).
- The clinical records of adults must be kept for 11 years after the last encounter.
- When more than one retention schedule applies to certain records, the stricter of the retention schedules must be applied.

Service provider agencies have the responsibility of fulfilling the record retention and disposition requirements for all the records generated within their agency. This includes responsibility for maintaining custody of the records for the duration of the retention period. Record retention is addressed in the provider MOA/contract with the LME as well as in the provider services agreement with the Division of Medical Assistance for direct enrollment to provide Medicaid-funded services.

Each provider must develop a retention and disposition plan outlining how the records are stored, who will be the designated records custodian and how the records custodian is going to inform the respective LMEs of what their process is and where the records will be located. The provider should send the responsible LME a copy of the storage logs identifying each individual served within their catchment area, the dates of service and into which box a record is stored. A sample storage log is attached.

The storage log can be used for all record types including service records, reimbursement records, personnel records, etc. The required identifying information consists of the:

- Agency name
- Department
- Date of storage
- Series number
- Box number
- Start date and the end date of the contents in the box
- Location of where the box is stored
- Record type or the name of the individual. Record type refers to the classification of the particular information contained the box. Generally one would store records of the same type in the same box; however, if a box contains more than one type of record, this needs to be so noted on the front of the box.
- Record number or any other identifying number, if there is one
- Date of birth is recorded for individual service records. In the case of personnel records, the employee's date of birth is to be recorded for quick reference.
- Timeframe of the information stored in a particular box. For example, you would record an admission of 9/2/07 – 9/13/09, or an employment period of 2/12/03 – 2/13/09 or a specific timeframe (e.g., October 2002 Cost Reporting, etc).
- Storage media (i.e., paper/hard copy, microfilm, tape, disc)

Endorsement Update

The LME Directors were notified by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) on September 18, 2009 that the LMEs are authorized to triple the endorsement time frames until further notice. As consumers are transitioned from Community Support to other appropriate services it is important to ensure adequate time for the endorsement process to occur. With funding reductions and fewer LME staff to conduct endorsement activities the extension of the process will help LMEs adequately evaluate provider qualifications for endorsement.

Per the endorsement policy timelines, the LME will endorse a provider within approximately 50 days or less if the original application packet and on-site review meet all requirements. However, with endorsement timeframes tripled, if the original application packet and on-site review meet all requirements, the endorsement process *may* take up to approximately 150 days. It is important to note that this extension is permissive; we expect that LMEs will prioritize endorsement for evidence-based services or services that are critically needed within its catchment area. This authorization to triple the endorsement timelines went into effect on September 18, 2009 and applies to all timelines related to endorsement except the three year re-endorsement requirement. Providers are still expected to be re-endorsed every three years under the current policy guidelines.

In addition, the Plan of Correction process for initial endorsement has been eliminated. Providers must be able to demonstrate compliance with the service definition checksheets and business verification during the initial endorsement review. Endorsement will be denied if the provider fails to meet the requirements of endorsement for the initial business verification or the on site endorsement review.

Medicaid Enrollment Effective Date

Effective immediately, the Division of Medical Assistance will no longer honor provider requests to amend their enrollment effective date after the issuance of their Medicaid provider number.

CAP-MR/DD Update

Required Documents for DD Submission to ValueOptions

In Implementation Update #59 there are errors related to required documentation for DD submission to ValueOptions. This is specific to two items, TCM Request and CAP Provider Change Only. Following is the original language and the correction.

Per Implementation Update #59: TCM Request
Initial TCM request requires NC-SNAP and comprehensive Clinical Assessment (current psychological) be submitted with Intro or Complete PCP and CTCM.

Correction: TCM Request
Initial TCM request requires NC-SNAP and comprehensive Clinical Assessment (current psychological) be submitted with Intro (NON-CAP-MR/DD PCP) or Complete PCP and CTCM.

Per Implementation Update #59: CAP Provider Change Only
- Cost Summary
- CTCM to discharge previous provider
- CTCM to add new provider

Correction: CAP Provider Change Only
- PCP Update (per the Records Management and Documentation Manual for Providers of Publicly-Funded MH/DD/SA Services CAP-MR/DD Services and Local Management Entities)
- Cost Summary
- CTCM to discharge previous provider
- CTCM to add new provider

CAP-MR/DD Re-Endorsement
The *Policy and Procedures for Endorsement of Providers of Medicaid Reimbursable MH/DD/SA Services (12/3/07),* requires providers of Medicaid reimbursable services to secure re-endorsement every three years.

Attached is a standardized Letter of Attestation for CAP-MR/DD providers. CAP- MR/DD providers shall submit the Letter of Attestation and supporting documentation to the LME located in the catchment area where the provider's corporate office is located. In the event that a provider does not deliver services where the corporate office is located and was endorsed by another LME, the provider shall submit the Letter of Attestation to the LME which endorsed the service, certifying that the provider continues to meet CAP-MR/DD service requirements. That LME is responsible for completing the Notification of Endorsement Action (NEA) letter for the provider regarding CAP-MR/DD services. The provider is responsible for submitting the NEA to other LMEs that contract with (signed MOA) the provider for the same CAP-MR/DD services. It is the responsibility of the provider to initiate this process. Providers shall submit the Letter of Attestation to the LME within 30 days prior to the expiration of the previous endorsement notification.

The Letter of Attestation shall include:
- Proof that the provider has met the required national accreditation benchmarks
- Certificate of insurance
- Report of any dissolutions, revocations, or revenue suspensions that have occurred within the last three years
- Current business information requested on the Letter of Attestation

Once the LME reviews and approves the information in the Letter of Attestation, the LME completes a Notification of Endorsement letter indicating the new effective dates of endorsement for CAP-MR/DD services (for a period of up to three years).

CAP-MR/DD provider endorsement and enrollment is statewide; therefore a provider is only re-endorsed once statewide by the LME where the provider's corporate office is located.

If a CAP-MR/DD provider does not submit a Letter of Attestation to the LME, the LME shall notify DMA by completing the NEA letter with notation in the comment section indicating the endorsement has expired and has not been renewed due to failure to submit the Letter of Attestation. In this case the LME shall take the following actions:
1. Send a copy of the NEA to the provider via certified mail noting the expired endorsement; AND
2. Notify other LMEs statewide; AND
3. Submit the NEA letter to DMA via electronic submission.

This shall be considered involuntary withdrawal and will include all CAP-MR/DD services the provider was endorsed to provide statewide. The provider may not apply to provide for CAP-MR/DD services anywhere in the state for six months.

Reminder: When an MOA with a CAP-MR/DD provider expires, if the provider has been re-endorsed for CAP-MR/DD services, the LME shall secure a new signed MOA.

Special Note: In the event the LME and provider have completed the re-endorsement process prior to this notification the process indicated in this notification is not required. Effective per the date of this notification the process shall be completed as required in this notification.

Self Direction within the Supports Waiver
The DMH/DD/SAS and the Division of Medical Assistance are engaged in the development of the operational details to implement the self direction option within the Supports Waiver. The *Self Direction in the Supports Waiver* is a summary of the self direction model included in the Supports Waiver. This summary is attached and provides the basic framework for the operational details of the self direction model. Additional information will be added to the website as information is finalized.

Supports Intensity Scale-SIS
The DMH/DD/SAS has launched the Supports Intensity Scale webpage found at http://www.ncdhhs.gov/mhddsas/sis/index.htm. This webpage provides helpful information to families, individuals who receive services, providers and others wanting to learn more information about the Supports Intensity Scale (SIS) in North Carolina. It also contains a current list of state SIS Examiners. In addition, the webpage provides links to other state's (outside of NC) specific information about their use of the Supports Intensity Scale. The webpage will be updated periodically introducing new information as it becomes available.

CAP-MR/DD Slot Action Guidance: Terminations, Deinstitutionalization (DI), Money Follows the Person (MFP), Emergency and Reinstatement
The attached *Guidance for Documents/Procedures Required for CAP-MR/DD Slot Actions: Terminations, DI, MFP, Emergency and Reinstatement* document provides information regarding the procedures and documentation required for LMEs to request specific CAP-MR/DD slot actions. These procedures and documentation requirements are intended for use by the LME in the following situations; Terminations, Deinstitutionalization, Money Follows the Person, Emergency and Reinstatement. The LME is responsible for following the procedures and submitting the required documentation to the DMH/DD/SAS with slot requests.

Medicaid Reimbursement Rate Update
Due to legislated budget reductions, effective July 1, 2009 there was no annual inflationary adjustment in reimbursement rates for Medicaid participating providers. Rates effective with date of service July 1, 2009 were held at existing rates as of June 30, 2009; except Medicaid rates were adjusted downward in accordance with the current year's downward adjustments to the Medicare fee schedule.

Effective with date of service October 1, 2009, rate reductions (annualized over nine months) that are delineated below will be applied to all public and private Medicaid providers except for federally qualified health centers, rural health centers, school-based and school-linked health centers, State institutions, hospital outpatient, pharmacy, hospice and the non-inflationary components of the case-mix reimbursement system for skilled nursing facilities. Critical Access Hospitals will continue to have their inpatient and outpatient Medicaid costs settled at 100%.

The annualized reductions resulted in overall program reduction percentage that differs from the actual rate reduction percent applied. In some programs the rates reduction percentage was not applied uniformly.
Updated fee schedules have been published for all current rates on the DMA website at http://www.dhhs.state.nc.us/dma/fee/fee.htm. Providers are reminded to bill their usual and customary rates when submitting claims to NC Medicaid.

The overall program and rate reduction percentages are listed below with additional explanatory information detailed.

Program	Program Reduction %	Over All Rate Reduction %
Waivers: CAP MR/DD, CAP DA, CAPCHOICE, CAP CHILD	*	*
ICFMR	-5.00%	
Rehabilitative Services	-4.68%	Various****
Psychiatric Residential Treatment Facilities	-4.28%	-8.05%

*Rates for waiver services vary due to parity between State Plan rates and the waivers.
**Case Management: the following procedure codes and rates are applicable for all providers in all Medicaid waivers and programs except as specifically noted for At-Risk Case Management and HIV Case Management:

Procedure Code	Description	Old Rate	New Rate	Effective Date
S9445	Patient Education, Not Otherwise Classified, Non-Physician Provider (1unit=15min.)	$16.50	$14.43	10/01/2009
T1016	Case Management, Each 15 Minutes	$15.25 and $21.74	$14.43	10/01/2009
T2041	Supports Brokerage, Self-Directed, Waiver; Per 15 Minutes	$15.25	$14.43	10/01/2009
T1017	Targeted Case Management (One Unit = 15 Minutes)	$29.30	$17.76	10/01/2009
T1017 HI	Targeted Case Management (One Unit = 15 Minutes)	$18.75 and $29.30	$17.67	10/01/2009
T1017	Targeted Case Management (One Unit = 15 Minutes) for **At-Risk Case Management and HIV Case Management**	$13.82	$13.22	10/01/2009

*** **Primary Care Physicians** codes for *Physician Evaluation and Management Services* can be billed by other providers. The rates for these services were not reduced and are held at the January 1, 2009 rate. The -9.00% rate reduction was applied to all of the other Physician Services Procedure codes rendering the -4.90% over all program reduction.

Code	Description
99201 – 99205	New Patient office visit codes
99211 – 99215	Established Patient office visit codes
99217	Observation care discharge
99218 – 99220	Initial observation care
99221 – 99223	Initial hospital care
99231 – 99233	Subsequent hospital care
99234 – 99236	Observation or inpatient care services (admission and discharge on the same day)
99238 – 99239	Hospital discharge day management
99291 – 99292	Critical care
99304 – 99306	Initial nursing facility care
99307 – 99310	Subsequent nursing facility care
99315 – 99316	Nursing facility discharge services
99318	Evaluation and management of a patient involving an annual nursing facility assessment
99324 – 99328	Domiciliary, rest home (e.g., boarding home), or custodial care services new patient
99334 – 99337	Domiciliary, rest home (e.g., boarding home), or custodial care services established patient
99341 – 99345	Home visit for the evaluation and management of a new patient
99347 – 99350	Home visit for the evaluation and management of an established patient
99354 – 99355	Prolonged physician service in the office or other outpatient setting
99356 – 99357	Prolonged physician service in the inpatient setting
99367	Medical team conference with interdisciplinary team; participation by physician (DMA limits to use for case conference for sexually abused children. See policy 1A-5)
99375	Physician supervision of a patient under care of home health agency requiring complex and multidisciplinary care modalities within a calendar month; 30 minutes or more
99378	Physician supervision of a hospice patient requiring complex and multidisciplinary care modalities within a calendar month; 30 minutes or more
99381 – 99387	New patient initial comprehensive preventive medicine E/M
99391 – 99397	Established patient periodic comprehensive preventive medicine E/M
99406 – 99407	Smoking and tobacco use cessation counseling visit
99408 – 99409	Alcohol and/or substance abuse structured screening and brief intervention (SBI) services
99420	Administration and interpretation of health risk assessment instrument
99460 – 99463	Newborn care services

**** The Rehabilitative services are comprised of the Mental Health Independent Professional Practitioners, the Residential Treatment program, and the Enhanced Mental Health services.

The program change information is listed in the tables below:

Program	Service	Program Reduction %	Rate Reduction %
IPP	All CPT	-2.93%	various
IPP	All H - Codes	-6.10%	-8.14%
Residential Treatment	HRI Level I HRI Level II - TFC HRI Level II - Group Homes	-3.94	-5.25%
Residential Treatment	HRI Level III HRI Level IV	-4.38	-5.85%
Enhanced Mental Health	All procedure codes with the exception of the four services held harmless [1]	-4.79%	-9.62%

The services listed below are not part of the rate reduction for Rehabilitative services and their rates remain at the current rate.

Code	Description	Current Rate
H2011	Mobile Crisis Management	$ 34.37
H2022	Intensive In-Home Services	$ 258.20
H2033	Multi-systemic Therapy	$ 37.32
ACTT	Assertive Community Treatment Team	$ 301.35

Please refer to the published fee schedules for all current rates on the DMA website at http://www.dhhs.state.nc.us/dma/fee/fee.htm. Providers are reminded to bill their usual and customary rates when submitting claims to NC Medicaid.

Please direct any questions to Roger Barnes, Assistant Director - Finance Management, at 919-855-4183.

Notice of Medicaid Identification Card Changes

Beginning September 8, 2009, the N.C. Medicaid Program began issuance of one Medicaid identification (MID) card per year to each recipient (see September Provider Bulletin article "Notice of Medicaid Identification Card Changes" http://www.ncdhhs.gov/dma/bulletin/0909bulletin.htm#mid). The new annual cards are printed on gray stock. The blue, pink, green, and buff-colored MID cards are no longer being issued. The new cards include the case head name, recipient name, MID number, issue date, and Community Care of North Carolina/Carolina ACCESS (CCNC/CA) primary care provider information (if applicable). The new cards do not indicate dates of eligibility, Medicaid program or special coverage. Recipients who are issued new cards may have been approved for prior months only, the current month only, or an ongoing period of up to 12 months.

Because the new card no longer serves as proof of eligibility, it is essential that at each visit providers verify the recipient's:

- Identity (if an adult)
- Current eligibility
- Medicaid program (including restrictive programs such as Medicaid for Pregnant Women (MPW) and Family Planning Waiver (FPW)
- Special coverage (e.g.: Carolina Alternatives Program (CAP), Program of All Inclusive Care for the Elderly (PACE)
- CCNC/CA primary care provider information
- Other insurance information

To verify eligibility, a provider can choose to use the North Carolina Electronic Claims Submission/Recipient Eligibility Verification Web Tool (NCECSWeb), the real time or batch Eligibility Verification System (EVS), or the Electronic Data Systems (EDS) Automated Voice Response (AVR) system. Information on how to enroll and use the NCECSWeb tool can be found in the September Special Provider Bulletin article "North Carolina Electronic Claims Submission/Recipient Eligibility Verification Web Tool." For information regarding real-time and batch eligibility, contact the EDS Electronic Commerce Services (ECS) group at 1-800-688-6696 (option 1). Information about the AVR system is available in the July 2001 Special Bulletin, *Automated Voice Response (AVR) System Provider Inquiry Instructions*, which is located at http://www.ncdhhs.gov/dma/bulletin/. To access the AVR system, call EDS at 800-723-4337.

The above methods will not only serve to verify eligibility, but also inform the provider as to whether the recipient is entitled to any special services, such as PACE or CAP, or enrolled in a restrictive program, such as FPW or MPW. Recipients enrolled in PACE receive their medical care exclusively through the PACE organization. When using the AVR system, it is therefore important that providers listen to the entire recorded message and follow prompts as directed or important parts of eligibility information may be missed.

Unless noted otherwise, please email any questions related to this Implementation Update to ContactDMH@ncmail.net.

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